2015 APAAC ANNUAL VICTIM ADVOCATE CONFERENCE

TRAUMA INFORMED ADVOCACY

Presented by: Linda Smith - Victim Advocate
Town of Gilbert Prosecutors Office

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GOALS

The goal of this presentation is to gain knowledge about how trauma can impact individuals. And, how we, as Victim Advocates, can work more effectively with these individuals and minimize re-traumatization.

OBJECTIVES

After this presentation you will have gained a basic understanding of trauma and the impact of trauma on the brain and on individuals.

Additionally, you will be able to recognize trauma symptoms in the individuals for whom you provide services and will realize how to more effectively work with these individuals while minimizing the potential for re-traumatization.

My hope is that...

You will gain insight into trauma responses from the victim's point of view and begin to understand that, to these individuals, their responses make sense.

Also, as you realize the challenges that exist in our system, you will have a desire to develop strategies to overcome those challenges

What is TRAUMA?

- There is NO SINGLE DEFINITION
- What does that tell us....
- It's a VERY COMPLICATED CONCEPT!

What We DO Know...

- The most important definition of trauma comes from the individual who experiences the trauma.
- An individual's interpretation of life events will form their definition of trauma...unique to that individual.
- And, a combination of their perception and the physiological impact on their brain will shape their behavior and reactions to the world around them.
- NOT understanding this, and I mean really internalizing this, will hamper your helping efforts.
- Understanding this will help you work much more effectively with traumatized individuals.

EFFECTS OF TRAUMA

How Trauma Impacts the Brain and the Body

Trauma Components

- Stress
- Crisis
- Repeated trauma
- Single event trauma
- Physical and/or sexual abuse
- Emotional abuse, neglect or dysfunction
- Coping skills (Capacity/ability)

Brain Basics

- The SURVIVAL BRAIN
  - Fight, flight, freeze
  - First to develop
- The THINKING BRAIN
  - The Command Center
  - The Decision Maker
  - Last to develop
- The FILE CABINET
  - Where memory is stored

The Trauma Functioning Brain

- LET'S LOOK AT SINGLE EVENT TRAUMA
  - Survival Brain
  - Thinking Brain
  - File Cabinet
  - Potential for long term dysfunction?
  - Potential for mental health disorder development?

The Trauma Functioning Brain

- LET'S LOOK AT LONG-TERM, PERVASIVE TRAUMA
  - Survival Brain
  - Thinking Brain
  - File Cabinet
  - Potential for long term dysfunction?
  - Potential for development of mental health disorder?
  - Potential for development of substance use disorders?
  - What is the trauma is inflicted by a significant caregiver?

What We Now Believe

- Recent studies support the conclusion that the impact of trauma is not only cumulative – the more times a traumatic event is experienced the greater the impact – but also additive: exposure to additional different types of trauma is correlated with greater impact (Finkelhor, Ormrod, Turner, & Hamby, 2005; Turner & Lloyd, 1995; Turner et al., 2006). To this we would add that the impact of trauma is summative: the combination of event(s) plus impact is what individuals carry forward through time inscribed in memory, sense of self, and behavior.

How Do We Classify the Impact?

- In all of these studies the impact of trauma is most easily captured in symptoms labelled psychological or physical. Less easy to capture, much less to quantify, are lack of trust (Sadavoy, 1997), fear of forming relationships, and lack of ease in one's being (Briere & Elliott, 1994) – the disorientation and disconnection that trauma creates (Saakvitne, 2000). Such impact is difficult to describe but not difficult to understand, especially when we consider that many perpetrators of childhood sexual abuse are a parent or someone in a caretaking role (Finkelhor, 1994).

The Resulting Psych Disorders

- Partly because PTSD is the most widely known impact of trauma but also for other complex reasons, trauma's impact is often seen in terms of symptoms of psychological disorders. Dissociation, flashbacks, and nightmares that are among the diagnostic criteria of PTSD are not the only symptoms associated with experiencing violence designated by mental illness diagnoses. Diagnoses of depression, anxiety and panic disorders, obsessive compulsive disorder, psychotic disorders, and eating disorders are commonly given to individuals who have experienced violence (Allen, Huntoon, & Evans, 1998; Briere & Elliott, 1994; Browne & Finkelhor, 1986; Margolin & Gordis, 2000). Antisocial personality disorder, in which anger is externalized in the form of aggression, is diagnosed more frequently among men than women with histories of trauma; among women with such histories, a more common diagnosis is borderline personality disorder, which can be characterized as an internalization of anger (Stewart & Harmon, 2004, p. 251), as well as by self-inflicted violence (a commonly misunderstood coping strategy for the repercussions of trauma) (Mazelis, 2003).

The Resulting Substance Abuse Disorders

- Studies have repeatedly shown that substance abuse is correlated with a history of physical and/or sexual abuse, with drugs and alcohol often serving as self-medication for the experiential impact of trauma (e.g., Blume, 1990; Brown & Anderson, 1991; Covington, 1996; Fullilove et al., 1993; Herman 1992b; Miller 1994; Reed & Leavitt, 1996). The links between trauma and substance use are many and complex. Using substances can make women more vulnerable to rape or other violence and may lead them into prostitution or exchanging sex for drugs (Carlson & Siegal, 1991; Fullilove et al., 1992). Yet for many women, abuse as children or youth preceded their problems with alcohol or drugs and any physical or sexual abuse they experience as adults (Cohen et al., 2000; Zierler et al., 1991).

Co-Occurring Disorders

Among both men and women with histories of trauma, substance use and symptoms designated "mental illness" often co-occur. For example, an estimated 38% of men in substance abuse treatment have PTSD (Najavits et al., 2005), and the Substance Abuse and Mental Health Service Administration's Women, Co-Occurring Disorders, and Violence Study readily recruited 2,729 women who had experienced physical and/or sexual abuse and also had both substance use and mental health diagnoses (Becker et al. 2005, McHugo et al. 2005b). In a sample of 78 homeless individuals diagnosed with co-occurring substance abuse and mental health disorders, 100% of the women and 68.6% of the men reported lifetime experience of trauma (Christensen et al., 2005; see also Criminal Justice Systems Issues and Response in Times of Disaster resource paper for an overview of research on the prevalence of trauma histories, substance abuse, and mental health issues among incarcerated individuals.)

Working Effectively with Individuals Who Have Experienced Trauma

That doesn't make sense...
or does it???

What is TRAUMA INFORMED?

- Living through traumatic events changes the ways the self and the world are experienced. In the words of Judith Herman (1992b, p. 135), "[t]he core experiences of . . . trauma are disempowerment and disconnection from others." Alternatively phrased, trauma as event – or events – creates trauma as experience, at the center of which is damage to individual agency, "self-in-relation" (Miller, 1976), trust, and safety. We designate the effects of trauma as its "impact" because this singular term reminds us that human trauma, though often multiple in its manifestations, is unitized in arising solely from traumatic events and requires helping responses which, however manifold, should be uniform in being "trauma-informed" (Fallot & Harris, 2001; Harris & Fallot, 2001).

Trauma Informed Care

- We need an understanding of how trauma has impacted our victims.
- The major paradigm shift that has occurred as we have moved toward trauma informed care is that we have moved away from negative, deficit based models, which asked the question "Tell me what is **WRONG with you?**", to positive, strength based models which ask the question, "Tell me what has **HAPPENED TO YOU?**"
- This model identifies individual strengths, removes blame and provides HOPE.
- It recognizes INDIVIDUALS, embraces culture and is non-judgmental.

Their Reactions Do Make Sense

- When the brain becomes conditioned it will, or may, perceive a threat even when none is there.
- The way the individual may react (not respond) can seem inappropriate for the event, ineffective or over-reactive.
- Difficult for you because you don't know the ins and outs of their triggers and you may unintentionally set off a trigger.
- It's not your fault and it's not their fault. You did not re-victimize them or re-traumatize them, it's just how their brain reacts.
- At that point, reach to understand so you can move forward.

When We First Met...

- Things to consider at the first meeting.
  - Phone
  - In person
- Wipe the slate clean
  - Stigma, stereotypes and biases
- Snapshot view
  - Where you meet someone does not represent where they've always been or where they will always be.

FIND STRENGTHS and INSTILL HOPE

Things I've Learned...

- There's no silver bullet!
- We're all adults here!
- Listen and learn from them.
- Avoid surprises, to the extent that you are able.
- Remember that what you might see as the problem, was, at least at one time, their solution.
- Coping skills, coping skills, coping skills.

More Things I've Learned...

- ASIST model is sooooo very useful and effective.
  - The ADHS risk assessment is very similar.
- Motivational Interviewing is very effective.
- Risk/benefit exercise is helpful...and the individual cannot deny it because they wrote it.
- Writing/journaling – helps with the individual's processing skills.
- Instead of praise, get them to explain their successes. It strengthens their processing skills.

Putting It All Together

- Emotional safety
  - Managing feelings
  - Take a break
  - One step at a time
- Allow the individual to correct you and/or say no.
- Help them identify strengths.
- Find out what **they** want.
  - It's their life and no one but them walks in those shoes.
  - Meet them where they're at.

Remember…

People will forget what you've *said*,
but
NOT HOW YOU MADE THEM *FEEL*.

Moving Beyond the System

- Help them think beyond…where they will live.
- Making a Mental Health or Substance referral
- Keep learning, keep growing.
- Get as much training as you possibly can
- Motivational Interviewing
- ASIST
- Trauma training
- Things ARE changing…for the better!

Communication Styles

- Aggressive
- Passive
- Passive Aggressive
- Assertive
  - OPEN
  - HONEST
  - EQUAL
  - DIRECT

MODEL THE BEHAVIOR YOU WANT TO SEE

Say what you mean...
Mean what you say...
and
Don't say it mean!

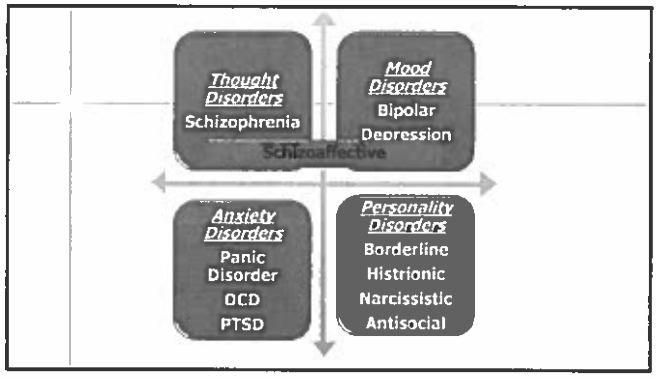
Borderline Personality Disorder
Diagnostic Criteria

- Fear of abandonment
- Unstable / intense relationships
- Unstable self-image / sense of self
- Impulsivity
- Recurrent acts intended to inflict self-harm and suicidal ideation
- Mood instability
- Chronic feelings of emptiness
- Difficulty controlling anger
- Transient paranoia / dissociation

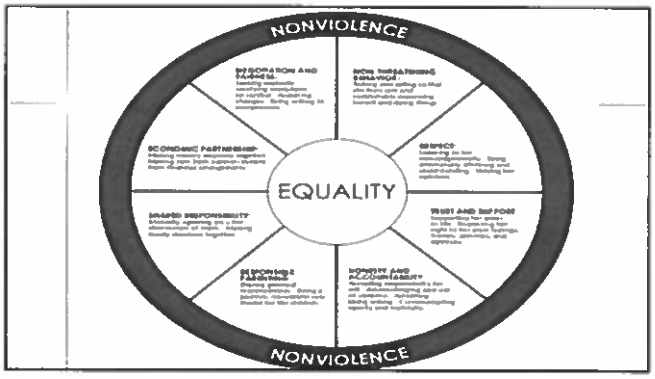
Antisocial Personality Disorder Diagnostic Criteria

Pattern of disregard for and violation of the rights of others since age 15:

- Breaking the law
- Lying / deceitfulness for profit or pleasure
- Impulsivity
- Irritability / aggressiveness
- Disregard for safety of self / others
- Irresponsibility
- Lack of guilt or remorse


Thought Disorders
Schizophrenia
Mood Disorders
Bipolar
Depression
Schizoaffective
Anxiety Disorders
Panic
Disorder
OCD
PTSD
Personality Disorders
Borderline
Histrionic
Narcissistic
Antisocial


VIOLENCE
PHYSICAL
SEXUAL
POWER AND CONTROL
VIOLENCE
PHYSICAL
SEXUAL


NONVIOLENCE
EQUALITY
NONVIOLENCE

NATIONAL RESOURCES

- National Center on Domestic Violence, Trauma & Mental Health
- SAMHSA – Substance Abuse Mental Health Services Administration (CSAT – establishes policy for SAMHSA)
- NIMH – National Institute of Mental Health
- NIDA – National Institute on Drug Abuse
- NIAA – National Institute on Alcohol Abuse and Alcoholism

STATE RESOURCES

- ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
  - RBHAs – Regional Behavioral Health Authority
    - October 2015 - New RBHAs for northern and southern Arizona
- NAMIAZ – National Alliance on Mental Illness, Arizona Chapters
- Arizona AA or NA – Arizona Alcoholics Anonymous or Narcotics Anonymous

Lectures and Trainings

- ASU CABHP – ASU Center for Applied Behavioral Health Policy
  - Motivational Interviewing
- ASIST – Applied Suicide Intervention Training
  - LivingWorks, Canada
- Trauma Training/Suicide Training – Dr. Robert Rhoton, Ottowa University

Thank You!

- Please feel free to use me as a resource!
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What was the one most valuable thing...

- You will take away from today's information?
- Thank you for being here, for listening and learning.
- I hope something you heard today resonated with you and you will try something new as you interact with your 'survivors' in the future.